

San Juan Health Services Employment Application

PLEASE PRINT CLEARLY IN INK

POSITION APPLIED FOR _____ DATE OF APP _____

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 LAST NAME FIRST NAME MIDDLE NAME
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HOME ADDRESS P.O. BOX APT # CITY STATE ZIP CODE

TELEPHONE NO. AREA CODE E-MAIL U.S. CITIZEN IF NO VISA TYPE AND NO. IS YOUR AGE:
 YES NO YES NO UNDER 18 YES NO
 OVER 70 YES NO

LIST ANY REASON KNOWN TO YOU WHY YOU MIGHT NOT BE ABLE TO PERFORM CONSISTENTLY AND PROMPTLY ANY DUTIES OF THIS POSITION

DATE AVAILABLE STARTING SALARY NEEDED WILL YOU ACCEPT ANOTHER POSITION? YES NO
 IF YES, PLEASE SPECIFY:

WILL YOU ACCEPT SHIFT WORK? YES NO WOULD YOU WORK FULL TIME PART TIME
 WILL YOU ACCEPT WEEKEND WORK? YES NO

WERE YOU PREVIOUSLY EMPLOYED AT ANY SAN JUAN HEALTH SERVICES FACILITY'S? YES NO

IF YES WHERE _____ WHEN _____ WHAT CAPACITY _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO DO YOU HAVE A FRIEND OR RELATIVE WORKING HERE? YES NO
 IF YES GIVE DATE, OFFENSE AND DISPOSITION NAME DEPT RELATIONSHIP

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EMPLOYMENT HISTORY

LIST MOST RECENT POSITION FIRST

FROM NAME OF EMPLOYER NAME/TITLE OF LAST SUPERVISOR
 MO. YR.

TO ADDRESS STREET CITY STATE TELEPHONE NO
 MO. YR.

JOB/POSITION ESSENTIAL JOB DUTIES: ENDING SALARY

REASON FOR LEAVING: MAY WE CONTACT THIS EMPLOYER
 YES NO

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 FROM NAME OF EMPLOYER NAME/TITLE OF LAST SUPERVISOR
 MO. YR.

TO ADDRESS STREET CITY STATE TELEPHONE NO
 MO. YR.

JOB/POSITION ESSENTIAL JOB DUTIES: ENDING SALARY

REASON FOR LEAVING: MAY WE CONTACT THIS EMPLOYER
 YES NO

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 FROM NAME OF EMPLOYER NAME/TITLE OF LAST SUPERVISOR
 MO. YR.

TO ADDRESS STREET CITY STATE TELEPHONE NO
 MO. YR.

JOB/POSITION: ESSENTIAL JOB DUTIES: ENDING SALARY

REASON FOR LEAVING: MAY WE CONTACT THIS EMPLOYER
 YES NO

IF YOU HAVE OTHER PAST EMPLOYMENT PLEASE ATTACH SEPARATE SHEET OR RESUME

AN EQUAL OPPORTUNITY EMPLOYER
 SAN JUAN HEALTH SERVICES DISTRICT IS AN AT WILL EMPLOYER
 WE ARE A "DRUG FREE" WORK PLACE • WE DO DRUG TESTING • WE DO CRIMINAL BACKGROUND CHECKS

EDUCATION

SCHOOL	NAME OF SCHOOL	LOCATION	YEARS	DID YOU GRADUATE?
HIGH SCHOOL				YES NO GED
TRADE				CERTIFICATE OR LICENSE
COLLEGE				DEGREE
PROFESSIONAL				DEGREE/LICENSE
OTHER				

PLEASE LIST PROFESSIONAL LICENSES
 CERTIFICATIONS OF PERMITS HELD _____ NUMBERS _____ EXP DATE _____
 DO NOT INCLUDE DRIVERS LICENSE
 _____ NUMBERS _____ EXP DATE _____
 HAS (HAVE) YOUR LICENSE(S) EVER BEEN SUSPENDED OR REVOKED? YES NO IF YES WHY? _____
 PROFESSIONAL MEMBERSHIPS _____

APPLICANTS CERTIFICATON

I CERTIFY THAT ALL MATTERS CONTAINED IN THIS APPLICATION ARE TRUE AND AGREE THAT ANY MISLEADING OR FALSE STATEMENTS WOULD RENDER THIS APPLICATION VOID AND WOULD BE SUFFICIENT CAUSE FOR IMMEDIATE DISMISSAL IN THE EVENT OF EMPLOYMENT.

I FURTHER UNDERSTAND THAT THIS IS AN APPLICATION FOR EMPLOYMENT AND THAT NO EMPLOYMENT CONTRACT IS BEING OFFERED.

I AGREE, IF EMPLOYED, TO ABIDE BY ALL SAN JUAN HEALTH SERVICES DISTRICT RULES AND REGULATIONS. I UNDERSTAND THAT SUCH EMPLOYMENT IS FOR AN INDEFINITE PERIOD OF TIME AND THAT THE COMPANY CAN CHANGE WAGES, BENEFITS AND CONDITIONS OF EMPLOYMENT AT ANY TIME.

I HERREBY AUTHORIZE SAN JUAN HEALTH SERVICES DISTRICT TO INVESTIGATE ALL MATTERS CONTAINED IN THIS APPLICATION AND TO CONTACT PRIOR EMPLOYERS TO OBTAIN ANY AND ALL INFORMATION RELATED TO MY PAST WORK PERFORMANCE.

I HAVE READ AND UNDERSTAND THE ABOVE.

SIGNATURE

DATE

OFFICE USE ONLY

POSITION HIRED FOR: _____

DATE HIRED: _____ STARTING WAGE: _____ PER _____

SCHEDULED HOURS _____ PER WEEK COST CENTER _____ EMPL TYPE CODE _____

APPROVED BY _____ TITLE _____

SAN JUAN HEALTH SERVICES DISTRICT
SAN JUAN HOSPITAL – BLANDING MEDICAL CENTER – SAN JUAN CLINIC
AN EQUAL OPPORTUNITY EMPLOYER